LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

PRIORITIES & PLANNING (P&P) COMMITTEE MEETING MINUTES

April 23, 2013

P&P MEMBERS PRESENT	P&P MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Al Ballesteros, *Co-Chair*	Douglas Frye	Miguel Fernandez	Emily Gantz McKay (by phone)
Bradley Land, *Co-Chair*	Whitney Engeran-Cordova	Joseph Green	Jane Nachazel
Christopher Brown	Anna Long	Scott Singer	Glenda Pinney
David Kelly	LaShonda Spencer	Jason Wise	Craig Vincent-Jones
Abad Lopez	Carlos Vega-Matos		
Tonya Washington-Hendricks			
			DHSP STAFF
			Juhua Wu

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2) **Minutes**: Priorities & Planning (P&P) Committee Meeting Minutes, *3/26/2013*
3) **Summary**: Summary of Approaches Used for Assessing Unmet Need: Ideas and Examples from Ryan White Part A and Part B Applications, *2009*
4) **Report**: After the Estimate of Unmet Need – What Comes Next? Assessing and Addressing Unmet Need, *3/2009*
5) **Survey**: Mini-Survey on Unmet Need, Carried out Year-Round by Early Intervention Services Outreach Staff
6) **Survey**: "Proxy" Needs Assessment Questions for PLWH/A Now in Care Who Have Been Out of Care
7) **PowerPoint**: Early Intervention Services: A Method of Addressing Unmet Need and the Unaware Out of Care Populations, *8/9/2010*
8) **Guide**: A Practical Guide to Estimating and Assessing Unmet Need for HIV-Related Primary Medical Care, *8/2009*
9) **Spreadsheet**: Grant Year 22 Ryan White Part A, Single Allocation Model (SAM) Care and MAI Expenditures by Service Categories as of February 28, 2013, *4/22/2013*
10) **Summary Key**: Ryan White Parts A and B and MAI Expenditures by Service Categories, *3/18/2013*
11) **Work Sheet**: Fiscal Year 2014 Priority- and Allocation-Setting Change Matrix, *5/23/2013*
12) **Policy/Procedure**: #05.4001: Service Category Definitions and Related Rules and Regulation, *3/10/2012*

1. **CALL TO ORDER**: Mr. Land called the meeting to order at 1:30 pm.

2. **APPROVAL OF AGENDA**:
   MOTION #1: Approve the Agenda Order with Item 9 postponed **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION #2: Approve the 3/26/2013 Priorities & Planning (P&P) Committee Meeting Minutes **(*Passed by Consensus*)**.

4. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

5. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

6. **CO-CHAIRS' REPORT**: There was no report.

7. LOS ANGELES COUNTYWIDE HIV NEEDS ASSESSMENT (LACHNA):

A. Unmet Need Data Collection:

- Mr. Vincent-Jones noted needs assessment is done every two years. The last LACHNA was for care services only, but the previous one combined care and prevention as will future ones due to the unified planning body.
- At its last site visit, HRSA identified two items that required a response. One was that the care-only LACHNA did not address unmet need, i.e., those who are HIV+, but not in care. The care-only LACHNA recruited those receiving Ryan White services at agency sites which offer them. Unmet need was addressed by asking about previous experiences.
- The combined care and prevention LACHNA had a separate module with specific prevention questions though HRSA did not refer to it. Data was not optimal due to low numbers and inexperienced surveyors.
- The Commission is hiring Ms. Gantz McKay, Consultant to improve assessment of unmet need either within the context of the next LACHNA or separately. It also hopes to hire a staff person to work on it with HIV Epidemiology, Division of HIV and STD Programs (DHSP). Unmet need is likely to rise with migration pursuant to the Affordable Care Act (ACA).
- Ms. McKay said finding PLWH who are out of care is only exceeded in difficulty by finding PLWH who are unaware of their diagnosis. The first step in finding those who are out of care is to review existing data, e.g., surveillance data can indicate who is in care and help target those out of care by Viral Load and factors such as zip codes, age and gender.
- Four general categories of unmet need – PLWH who are aware of their diagnosis but are not in care – are:
  1. 8-12% of those in the Ryan White system do not receive primary medical care. ACA implementation may make addressing that population more complex, e.g., patients may require services such as transportation and care coordination to effectively access ACA medical care. Mr. Vincent-Jones noted 2,000 PLWH in the County's Ryan White system do not access its medical care, but it is not known if they have other medical care. Ms. Pinney added approximately 5% of the 450 respondents for the last LACHNA reported never receiving medical care for HIV.
  2. Some people complete medical care intake, but later fall out of care, e.g., due to problems with migration to other systems such as Medicaid, because a clinic closes or they dislike their physician. These can sometimes be tracked, e.g., if a telephone number is available. It is most effective to search for this population continuously year-round.
  3. The hardest unmet need population to find is those not connected to care after diagnosis and who have never been in care. Those not linked to care within 90 days are much more likely to not enter care for more than a year.
  4. Other groups may fall out of care due to particular circumstances especially:
     - ⇨ Those who experience repeated incarceration – 33-50% of incarcerated PLWH do not disclose their diagnosis;
     - ⇨ Those with mental health issues;
     - ⇨ Those who are new to the area;
     - ⇨ Those in substance abuse treatment programs – often not tested since, if under court order as many clients are, an HIV+ test would have to be reported, which agencies consider a breach of confidentiality;
     - ⇨ Those in homeless shelters.
- Understanding these populations helps guide targeting, e.g., high incidence in a zip code that includes a substance abuse treatment program can prompt a closer look at surveillance data for that area. HRSA defines "out of care" as the lack of a CD4 count, Viral Load and/or HIV medications for the prior year which can be assessed from surveillance data.
- Methods to assess unmet need and to bring people into care are similar, related and best used together, but not necessarily the same. Duchess City, NY initiated an approach to needs assessment approximately six years ago that is very effective and has been imitated by other jurisdictions. All outreach workers use a 10-12 question survey year-round on why individuals are not in care. In addition to collecting data, they try to link respondents to care.
- The first reason for not being in care was substance abuse issues; the second was lack of knowledge about free care.
- Mr. Vincent-Jones noted the Commission is required to do a needs assessment, but ethically should also link people to care. Medical Care Coordination (MCC) should assist in identification since it applies to everyone accessing Ryan White.
- He asked if Casewatch and surveillance data are compared. Ms. Wu said DHSP must do an unmet needs assessment for the application. The State Office of AIDS provides an unmet need match database with surveillance, Medicare, Medi-Cal and ADAP data to match with Casewatch. Data is sorted by age, gender and ethnicity and a map is created.
- Regarding HIPAA, Ms. McKay noted surveillance data covers the prior year per HRSA's definition of unmet need. Some jurisdictions have representatives contact those out of care. Others have agreements with their providers to do so.
- Ms. McKay said peers and agencies that work with the homeless are best at reaching them. Mr. Fernandez noted HOPWA requires an updated diagnosis form each two years which offers a window for linkage to care. He added the annual homeless count also includes some HIV questions and might add unmet need questions. Ms. Pinney said the count generally estimates 2-3% of homeless are HIV+ which is not consistent with HIV Epidemiology estimates.

- Ms. McKay reiterated the importance of multiple approaches to find those not in care by first identifying groups most likely to be out of care, addressing how best to reach each group and identifying reasons for being out of care.
- Mr. Vincent-Jones said testing, surveillance and Casewatch data might be triangulated to find those unknown to the Ryan White system and not in care. Ms. McKay added Disease Intervention Specialists (DIS) usually make the contacts.
- Mr. Singer noted the County is very large so someone might be known to one system, but not others. Ms. McKay said many areas are now using care community health workers for linkage to care. That requires discussing the process and identifying how it will work in lieu of where workers' contacts are and with whom they work.
- Mr. Ballesteros asked about social media. He has seen several people he knows to be out of care on Facebook. Ms. McKay replied efforts to date have been less effective than expected, but it is unknown if that was due to poor design.
- Ms. Wu said DHSP is using local surveillance data to map down to the local level. Results are being used to focus testing and that data is sent to DHSP where it is matched to surveillance data to see if the person is in care.
- DHSP is hiring more Public Health Investigators (PHIs), equivalent to a DIS. While expensive, data shows PHIs provide a high positivity return. Prevention Services is also reviewing expansion of partner notification services, including teaching PHIs to test and is working with MCC to ensure all PHIs have contact information to link people testing HIV+ to care.
- Ms. McKay noted some of those activities are targeted toward averting unmet need by linking people to care. Contacts can also be used to ask why people are not in care. A Colorado survey found the main two reasons were lack of service awareness and perceived expense. Phoenix, AZ trained 211/311 operators to assess service needs and refer to care, but it is best to use existing services because staff is more familiar with rules such as for HIPAA.
- Ms. Washington-Hendricks said many clients at AIDS Project Los Angeles lack computers and even phones so they will not be reached via social media. She asked about ways for a nutrition support program to reach clients. Ms. McKay said flyers in food bags work fairly well. Flyers need only say medical care is available and list times when someone will be in the office to help access care. She noted groups differ, e.g., young Latinos are very active on social media.
- Mr. Vincent-Jones said the Commission talked about a special allocation to address unmet need a few years ago, but subsequent budget cuts sidelined the discussion. He recommended resuming the discussion and expanding it to address the unaware. He believed unmet need may be overestimated and the unaware underestimated.
- Mr. Singer noted some have a Viral Load done solely to meet various documentation requirements. He asked if "unmet need" included achieving engaged care. Ms. McKay replied "unmet need" is defined as minimal care, but data shows those minimally engaged are more likely to fall out of care. Intervention should focus on linkage to and retention in care especially for those on the edge, e.g., one program targeted those who did not pick up their ADAP medications.
- ➲ Ms. Wu will verify whether or not PHIs following up on a syphilis call also check on HIV status. She believed they do.
- ➲ Request DHSP present at the 5/28/2013 P&P meeting on its unmet need activities and data preparatory to addressing unmet need during allocation-setting discussions.
- ➲ Ms. McKay will investigate whether there are or have been any HRSA SPNS grants or special initiatives for social media.
- ➲ Ms. McKay will review those jurisdictions that have used or are using pay incentives to bring people into care and report on their challenges and benefits.
- ➲ Ms. McKay will email a HRSA piece on the link between EIIHA and unmet need and the use of EIS to Mr. Vincent-Jones.
- ➲ Mr. Vincent-Jones will call Ms. McKay to discuss next steps and the P&P Committee will review packet materials.

8. **FY 2012 FINANCIAL EXPENDITURES**:
   - Ms. Wu reported there are no notable changes from last month. Estimates show maximization for Ryan White Part A, Part B/SAM Care and Minority AIDS Initiative funds. The fiscal year will be closed out in June or July 2013.
   - ➲ Agreed there was no need for a report at the 5/2/103 Joint Commission/Prevention Planning Committee meeting.

9. **FY 2013 ALLOCATION REVISIONS**: This item was postponed.

10. **FY 2014 PRIORITY- AND ALLOCATION-SETTING (P-AND-A)**: Attendees identified their conflicts-of-interest.
    A. **Service Category Priority Ranking**:
       - Mr. Vincent-Jones reminded the body that priority ranking solely addresses the need for a service regardless of how it is funded, e.g., it might be funded by another system of care. Allocations will be addressed at the 5/28/2013 meeting.
       - Ranking is based on such factors as the needs assessment, service utilization and planning body member experiences.

- Ms. Washington-Hendricks asked people to identify the basis for recommended changes and emphasize data driven sources such as the Los Angeles Coordinated HIV Needs Assessment (LACHNA). Mr. Vincent-Jones noted all information sources have limitations, e.g., LACHNA was done prior to initiation of Optometry and did not include populations such Case Management Home-based. Service utilization data is limited by the availability of services.
- Priorities have not changed significantly in the last few years, but clusters have reduced categories from 38 to 17.
- Mr. Land felt more attention to Benefits Support, especially Health Insurance Premiums/Cost-Sharing, was a growing need due to health care reform. He suggested follow-up on the new Optometry category and noted Oral Health Care continues to be an issue, especially for follow-up appointments after major procedures.
- Mr. Fernandez, Alliance for Housing and Healing, urged higher priority rankings for housing, housing supportive, mental health and substance abuse services. Many clients wait two months for a housing specialist and many are homeless with issues of poverty, mental health and substance abuse. Mr. Vincent-Jones cautioned that priorities pertain to relative need for a service versus other services. Excessive waits are an availability issue pertaining to allocations.
- Mr. Brown felt cost-sharing was a key issue because, while new systems are opening to clients, the cost to enter them may be prohibitive. He considers the treatment cascade key to priority ranking so stressed linkage to care and outreach along with Medical Care Coordination (MCC) and medical outpatient.
- Mr. Kelly felt mental health services should have a higher priority because it helps people accept linkage to care. There is often stigma pertaining to mental health especially in the Latino community,
- Mr. Lopez said the most important issue in his view is to facilitate permanent housing. Mr. Green added he brings a Red Cross perspective emphasizing shelter, food and clothing to priorities. Clothing is not applicable, but shelter is an emergent need and food is needed for medications. He also supported mental health services.
- Mr. Singer felt some categories are inherently related and should be ranked more closely to each other, e.g., Medication Assistance and Access and Benefits Support; Mental Health and Substance Abuse Services; and MCC and Case Management Home-based. He noted the latter provides MCC for its clients and has seen increased demand due to people aging with more co-morbidities such as heart disease, cancer, liver disorders and renal failure.
- Ms. Washington-Hendricks agreed mental health and residential services are often requested. She suggested using LACHNA and the Service Utilization Report (SUR) to determine the top five priority rankings especially regarding Mental Health Psychotherapy which is ranked among the top five requested services, but has a priority ranking of seven.
- The AIDS Project Los Angeles (APLA) food/nutrition program serves over 2,000 clients. Clients complete an Information and Referral Survey. Top five reported needs in order are: food, nutrition education, oral health care, benefits support and case management. Top three co-morbidities are: depression, high blood pressure and heart disease. Other issues vary by site, e.g., Long Beach reports higher substance abuse and South Los Angeles higher alcohol abuse.
- Mr. Vincent-Jones cautioned that need is not always what clients request. Substance abuse, in particular, is often underreported. It may also be intrinsically linked to mental health as substances may be abused as self-medication. Mr. Fernandez noted case mangers often uncover substance abuse by reviewing client history and asking pertinent questions. Mr. Singer added residential programs that require clients to be sober encourage underreporting.
- Mr. Kelly felt resistance to acknowledging a substance abuse issue may mitigate against a higher ranking. He was also unconvinced there was sufficient information to assume large numbers of clients would need help migrating due to health care reform changes or that Benefits Support would be needed if they did in lieu of other provided services. Mr. Vincent-Jones noted out-of-care data is always one year old so problems will not be well documented until 2015.
- Mr. Ballesteros felt data supported rankings much as they are with Mental Health and Benefits Support moved up. Individuals have requested optometry, but he felt information was insufficient to maintain its ranking at four.
- Mr. Singer noted initially the Optometry concept included screening for vision problems which will now stay within ophthalmology under Medical Specialty. He added APLA's optometrist for over 20 years has just terminated his services due to decreased demand. Mr. Singer suggested lowering Optometry and raising Mental Health priority rankings.
- Ms. Pinney said the LACHNA survey asked if certain substances were used in the last six months. Substance abuse did not rank in the top five. She added different populations have different needs, e.g., clients with very low incomes are not affected by cost-sharing. Mr. Vincent-Jones added DHSP estimates only about 10% of Ryan White clients have incomes at 200% or more of the Federal Poverty Level, but the number needing help will likely grow with migration.
- Mr. Brown noted workforce entry/re-entry was a major issue in Chicago and some programs grew significantly. He felt Rehabilitation Services might benefit from a higher ranking here as well. Ms. Pinney said the U.S. Department of Housing and Urban Development, the Department of Labor and other federal departments fund employment services.

Mr. Fernandez added many clients here are reluctant to return to work because they fear losing services and being unable to find a job.

- Ms. Wu will email the revised SUR to Mr. Vincent-Jones. It is also posted online.
- FY 2014 Priority Ranking Recommendations were as follows:

Service Category	FY 2014 Ranking	Change	FY 2013 Ranking	Reason for Change, *if any*
Medical Outpatient/Specialty	1	⇔	1	
Medication Assistance and Access ▪ AIDS Drug Assistance Program (ADAP) ▪ ADAP Enrollment ▪ Local Pharmacy Program/Drug Re-imbursement (LPP/DR)	2	⇔	2	
Oral Health Care	3	⇔	3	
Medical Care Coordination ▪ Medical Case Management ▪ Non-Medical Case Management	4	⇧	5	When the Affordable Care Act (ACA) is implemented in 2014, it is anticipated that RW patients/clients will need more help coordinating their services between multiple systems of care.
Mental Health Services ▪ Mental Health, Psychiatry ▪ Mental Health, Psychotherapy	5	⇧	7	Ranked higher due to increases in the proportion of clients with mental illness, especially among some key/priority populations (e.g., homeless), and the possibility that mentally ill clients may not indicate mental health need due to stigma.
Benefits Support ▪ Benefits Navigation ▪ Benefits Specialty ▪ Health Insurance Premiums/Cost-Sharing	6	⇧	8	Patient migration into Healthy Way LA already indicates that clients need more help navigating care system transitions and the availability of services; that need is expected to increase as the ACA is implemented.
Linkage to Care Services ▪ Counseling and Testing in Care Settings ▪ Outreach ▪ Partner Services ▪ Peer Navigation ▪ Treatment Education ▪ Transitional Case Management	7	⇩	6	Ranked lower because MCC, Mental Health Services and Benefits Support moved up in priority rankings.
Residential Care/Housing Services ▪ Emergency Shelter ▪ Hotel/Motel and Meal Vouchers ▪ Permanent Supportive Housing ▪ Residential Care Facilities for the Chronically Ill (RCFCIs) ▪ Transitional Housing ▪ Transitional Residential Care Facilities (TRCFs)	8	⇧	9	LACHNA data consistently ranks these services as among those that are most needed by RW patients/clients.

Retention in Care Services ▪ Child Care ▪ Health Education/Risk Reduction ▪ Language/Interpretation Services ▪ Legal Services ▪ Medical Transportation ▪ Nutrition Support ▪ Peer Navigation ▪ Peer Support ▪ Psychosocial Support Services	9	⇧	10	Ranked higher due to shifts in other service category priority rankings.
Substance Abuse Services ▪ Residential Substance Abuse Services ▪ Substance Abuse Treatment	10	⇧	11	
Housing Supportive Services ▪ Direct Emergency Financial Assistance (DEFA) ▪ Housing Case Management	11	⇧	13	
Medical Nutrition Therapy	12	⇔	12	
Optometry Services	13	⇩	4	Limited data to justify such a high priority ranking in 2013 given the other needs that will emerge in 2014 as a consequence of ACA implementation.
Home-based Care ▪ Home-based Case Management ▪ Home Health Care	14	⇔	14	
Long-Term and Palliative Care ▪ Hospice ▪ Skilled Nursing	15	⇔	15	
Rehabilitation Services ▪ Rehabilitation Services ▪ Workforce Entry/Re-entry	16	⇔	16	
Respite Care	17	⇔	17	

MOTION #3: **(*Washington-Hendricks/Land*)**: Approve the FY 2014 service category priority rankings, as presented **(*Passed: Ayes,*** Ballesteros, Brown, Kelly, Land, Lopez, Washington-Hendricks; ***Opposed,*** None; ***Abstention,*** None***)***.

11. **SPECIAL POPULATIONS**: ➲ P&P will review key populations, priority populations and populations of interest in the Comprehensive HIV Plan preparatory to consideration of how special populations might be addressed in allocations.

12. **FY 2013 P&P COMMITTEE WORK PLANNING**: This item was postponed.

13. **NEXT STEPS**: ➲ The next meeting will be extended to address allocations. It will be 5/28/2013 from 12:00 noon to 5:00 pm.

14. **ANNOUNCEMENTS**: There were no announcements.

15. **ADJOURNMENT**: The meeting adjourned at 4:45 pm.